COMMON GROUND
HEALTHCARE COOPERATIVE

Silver HSA 3000/80 LCS

	(✓) For Prior Authorization	In Network (You Pay)	Out-of-Network (You Pay)
Calendar Year Deductible		$3,000 self only/$6,000 family[1]	$6,000 self only/$12,000 family[1]
Coinsurance (applies only to certain services)		20%	50%
Maximum Out-of-Pocket (includes deductible, coinsurance, copays)		$4,500 self only / $9,000 family[1]	$9,000 self only / $18,000 family[1]
Office Visits			
*Primary Care Provider Visit (to treat an illness or injury)[2]		Deductible/Coinsurance	Deductible/Coinsurance
*Obstetrics/Gynecology Visit		Deductible/Coinsurance	Deductible/Coinsurance
*Specialist Visit		Deductible/Coinsurance	Deductible/Coinsurance
*Chiropractic Visit		Deductible/Coinsurance	Deductible/Coinsurance
*Hearing Exam		Deductible/Coinsurance	Deductible/Coinsurance
Diagnostic Services			
*Diagnostic Laboratory Tests		Deductible/Coinsurance	Deductible/Coinsurance
*Diagnostic X-rays		Deductible/Coinsurance	Deductible/Coinsurance
*Imaging (MRI, MRA, PET and CT Services only)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Allergy Testing		Deductible/Coinsurance	Deductible/Coinsurance
Mental/Behavioral Health & Substance Abuse			
*Outpatient - Office		Deductible/Coinsurance	Deductible/Coinsurance
*Outpatient - All Other Services		Deductible/Coinsurance	Deductible/Coinsurance
*Transitional		Deductible/Coinsurance	Deductible/Coinsurance
*Inpatient	✓	Deductible/Coinsurance	Deductible/Coinsurance
Emergency Services			
*Emergency Room[3] (waived if admitted)		Deductible/Coinsurance	Deductible/Coinsurance
*Physician Services		Deductible/Coinsurance	Deductible/Coinsurance
*Urgent Care		Deductible/Coinsurance	Deductible/Coinsurance
*Ambulance (ground and air)[4]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Hospital Services			
*Outpatient Surgical/ Ambulatory Surgical Care Centers	✓	Deductible/Coinsurance	Deductible/Coinsurance
Reconstructive Surgery	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Inpatient Hospital Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Maternity Services			
*Prenatal Care		Deductible/Coinsurance	Deductible/Coinsurance
* Inpatient Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Preventive Services			
*Preventive Service[5]		Covered in Full	No Coverage
Vision Services			
*Children's Vision Exam (1 exam per year)		Covered in Full	Covered in Full
*Children's Eye Glasses (1 pair per year)		Covered in Full	Covered in Full
*Adult Vision Exam (1 exam per 2 years)		Covered in Full	Covered in Full

Other Services			
*Transplants[6]	✓	Deductible/Coinsurance	Deductible/Coinsurance
Clinical Trials	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Habilitation Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Physical, Speech & Occupational Therapy (up to 20 visits each)	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Cardiac/Pulmonary Rehabilitation (up to 36 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Autism Spectrum Disorders	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Skilled Nursing Facility (up to 30 days per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Chemotherapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
Outpatient Radiation Therapy	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Hospice Services/End of Life Services		Deductible/Coinsurance	Deductible/Coinsurance
*Home Health Services (up to 60 visits per year)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Diabetes Education		Deductible/Coinsurance	Deductible/Coinsurance
Dialysis	✓	Deductible/Coinsurance	Deductible/Coinsurance
Infusion Therapy		Deductible/Coinsurance	Deductible/Coinsurance
*Non-Surgical Treatment for Temporomandibular Joint (TMJ)	✓	Deductible/Coinsurance	Deductible/Coinsurance
Specified Oral Surgical Procedures[8]		Deductible/Coinsurance	Deductible/Coinsurance
Routine Dental Services[7]		Please see below.[7]	
*Accidental Dental Services	✓	Deductible/Coinsurance	Deductible/Coinsurance
Prescription Drugs, Supplies & Equipment			
Prescription Medicines: **Retail** (30 day supply) Includes diabetic test strip **Mail Order**[9] (2 Copays per 90 day supply) Includes diabetic test strip **Preventive** (30 day supply) Medications defined in our formulary as preventive.		Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)	Deductible/Coinsurance **Preventive** - Covered in Full (see formulary for details)
*Specialty Drugs	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Durable Medical Equipment (Limited to a single purchase per DME type per 3 years)	✓	Deductible/Coinsurance	Deductible/Coinsurance
*Prosthetic Devices		Deductible/Coinsurance	Deductible/Coinsurance
Diabetic Equipment and Supplies		Deductible/Coinsurance	Deductible/Coinsurance
*Hearing Aids for Member over age 18 (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
*Hearing Aids for Members under Age 18. (Limited to one aid per ear every 36 months)		Deductible/Coinsurance	Deductible/Coinsurance
*Cochlear Implants for Members under Age 18.		Deductible/Coinsurance	Deductible/Coinsurance

This is a Schedule of Benefits only and does not replace the legal contract or certificate which identifies all covered services, additional details, limitations and exclusions of the coverage. For a complete description of covered services, please see your Member Certificate and any amendments to your Benefit Plan. If you have questions regarding Common Ground Healthcare Cooperative Benefits, please call Customer Service at 1-877-514-CGHC (2442).

✓ Prior Authorization is required for these services. Call 1-877-779-7598 for Prior Authorization. Failure to obtain Prior Authorization when required will result in the Member receiving a lesser Benefit. For Durable Medical Equipment, Prior Authorization is only required if the item is over $1000.

*Member will not be responsible for out-of-pocket amounts if member utilizes an Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization or through referral under contract health services, pursuant to 45 CFR 156.420(b)(2). These benefits have been identified as Essential Health Benefits but this does not mean all services under these categories will be subject to limited cost sharing. In addition, all services must meet all other requirements for coverage. Members should call Customer Service to determine the benefits provided under the plan.

[1] The deductible and out-of-pocket maximum in this plan are embedded. This means that if one family member meets the self-only deductible or self-only out-of-pocket maximum, the deductible and out-of-pocket maximum are satisfied for that family member. [2] Primary Care Provider includes general pediatrics, internal medicine, obstetrics/gynecology, family practice, general medicine and geriatrics.

[3] Copay will only apply to facility charge. All other charges related to ER visit are subject to deductible/coinsurance.

[4] Prior Authorization is only required for non-emergent ground and air ambulance.

[5] Federal Patient Protection and Affordable Care Act provides for coverage of certain Preventive Services based on age, gender and other health factors with no out-of-pocket expense to Member.

[6] Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

[7] Please refer to the Member Certificate to determine what oral surgeries procedures are covered.

[8] This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, agent, or the Federally Facilitated Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

[9] Only certain Prescription Drug products are available through mail order.